EXHIBIT D

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF MICHIGAN

SOUTHERN DIVISION

KOHCHISE JACKSON,	Case No.:
	2:19-cv-13382
Plaintiff,	Honorable
vs.	Terrence G. Berg
CORIZON HEALTH, Inc.,	Magistrate:
et al.,	Patricia T. Morris
Defendants.	

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Pages 1-116

The Virtual, Videotaped Deposition of Keith Papendick, M.D., taken pursuant to Notice in the above-entitled cause, via Zoom, on May 10, 2021, at 10:30 a.m., before Carol Marie Hicks, CSR-3345, Notary Public in and for the County of Livingston.

APPEARANCES:

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ALSO PRESENT: NEAL ROGERS, VIDEOGRAPHER

(All parties appeared via Zoom.)

INDEX TO EXAMINATIONS

EXHIBITS

EXHIBITS - (cont'd.)

(Attached.)

May 10, 2021
At or about 10:30 a.m.
KEITH PAPENDICK, M.D.
having first been duly sworn, was examined and testified on his oath as follows:
THE VIDEOGRAPHER: We are on the record. This is the video-recorded deposition of Dr. Keith Papendick, being taken remotely via Zoom. Today is May 10, 2021, and the time is 10:30 a.m.
Will the attorneys please identify themselves and the court reporter please swear in the witness.
MR. SCARBER: Good morning, Ian Cross on behalf of the plaintiff Kohchise Jackson.
MR. WILLIS: Kenneth Willis on behalf of defendants Prime and Colleen Spencer.
MR. SCARBER: Good morning, Devlin Scarber on behalf of the Corizon defendants, here with Dr. Papendick, and on his behalf.
EXAMINATION
BY MR. CROSS:
Q God morning, Dr. Papendick. My name is Ian Cross, I represent the plaintiff. Just want to go over a few ground rules before we start. This isn't an endurance test, so if you need a break at any time

just let me know. I just ask that you respond to the last question posed before the break if you want to take a break, okay?
A Yes.
Q And if you don't understand any of my questions, I don't want you to guess, I want to you ask me to clarify them.
A Yes.
Q Okay. What did you do for a living from January of 2014 to December of 2016?
A A utilization management physician.
Q Who did you work for?
A Quality Correctional Care of Michigan PC.
Q And what did you do for a living from January of 2017 to the present?
A Utilization management medical director for --
Q I think you're frozen, sir. I didn't get the answer to that second question. I think you froze or your screen froze, from my perspective.
A Yeah, something happened over here. Yeah?
Q Is it resolved now?
MR. SCARBER: Can you see him?
MR. CROSS: Yeah, I can see him.
THE WITNESS: Can you hear me?
MR. CROSS: I can.

MR. SCARBER: Yep, we got it. Something popped up on my screen, that's all. Go ahead.
MR. CROSS: Okay.
MR. SCARBER: He said he was still employed by --
A I worked for -- it's kind of a mixed-up situation in Michigan -- I worked for a company called Quality Correctional Care of Michigan PC, because physicians are not allowed to be employed by corporate.
BY MR. CROSS:
Q That'd be the corporate practice of medicine?
A That would be a corporate practice of medicine and we're not allowed to do that.
Q Do you know why you're not allowed to do that?
A State law.
Q Do you know why the State prohibits that practice?
MR. SCARBER: Just going to object to foundation.
BY MR. CROSS:
Q You can answer.
MR. SCARBER: You can answer, if you know and you can answer if you don't know.
A I can only surmise, and I'd rather not do that.

BY MR. CROSS:
Q Okay. So from January of 2017 to present, you worked for -- what was your job title?
A Utilization management medical director.
Q And how was that different from your previous job between 2014 and 2016?
A Utilization management at Corizon Health is now a corporate endeavor, i.e., we work together as a group for all of our state contracts.
Q So what changed, in terms of your job duties?
A Very little, actually.
Q Okay. Well, what changed?
A I'm placed under a different supervisor.
Q But were you doing the same tasks day in and day out?
A Yes.
Q Okay. What are your job duties?
A Evaluate requests from providers for off-site consults or follow-ups and either approve or defer those requests.
Q Do you have any other duties?
A No.
Q Do you respond to healthcare kites from inmates?
A Never. I've never seen one, since 2012 when I started working for them.

Q Do you respond to inmate healthcare grievances?
A Nope, never seen one.
Q Are you ever interviewed as part of the grievance process?
A No.
Q Do you ever personally meet with prisoners?
A No.
Q Do you ever meet with prisoners via telemedicine?
A No.
Q Okay. Do you review requests for off-site treatment for people in county jail?
A No.
Q Do you review requests for off-site treatment for prisoners in states other than Michigan?
A Only when colleagues are on vacation or on PTO.
Q Okay. And do they review requests for you when you go on vacation?
A Yes.
Q Okay. Do you participate in a weekly conference call?
A Yes.
Q What do you discuss in that conference call?
MR. SCARBER: Just going to place an objection to the extent it may go to anything regarding peer-review material or anything protected

by the Patient Safety Quality Improvement Act. But go ahead, to the extent that's --
A We talk about what's going on in the department, we talk about who's off next week, we talk about who's covering for next week, we talk about our nursing staff and who's covering -- going to cover when nursing staff is off. It's purely administrative.
Q Okay. You don't talk about your performance?
A No.
Q All right. So would it be fair to say that your primary job duties since 2014 has been reviewing requests for off-site care for DOC inmates?
MR. SCARBER: Just going to place an objection, asked and answered, but go ahead.
A I answered that, but yes.
BY MR. CROSS:
Q Okay. If I say the word 407 request, do you know what that is?
A It's a request in the medical record for Michigan Department of Corrections.
Q Continue, I'm sorry.
A That's all right, go ahead.
Q What is it a request for?
A Could be anything from a test to a procedure to a change in food, it's myriad.

Q So the requests you review, are they called 407 requests?
A No, they're off-site requests.
Q They're off --
A 407 is a number by -- that the MDOC use for when it was a paper process, and the paper number, form number, was 407, and it's just remained, been called that since, as far as I know.
Q Okay. How many off-site requests do you typically review in a day?
MR. SCARBER: Just going to place an objection, to the extent it calls for speculation, but if you know.
A I'm going to say 85 to 100.
BY MR. CROSS:
Q How many hours do you work per day?
A Ten to twelve.
Q Do you take a break for lunch?
A No, I do not.
Q So in a ten-hour day, you're spending, on average, say, six minutes per request?
A Some of them don't even take six minutes.
Q Okay. Do you --
A So you're taking -- nevermind.
Q Go ahead. Continue.

A You're extrapolating it to an average to all of them and you can't do that.
Q Okay. I understand that some will take longer than others. I'm just asking you what the average is.
Do you review the patient's medical record when you make a decision on an off-site request?
A All off-site requests are to be in total, they are to have everything I need to know to determine medical necessity.
Q Do you review the patient's medical record, besides what's in the request, when making a determination?
A Occasionally.
Q Occasionally. Okay. Has the number of requests you're asked to review gone up or down since you began doing this job in 2014?
A I would say it's about the same.
Q About the same. Is there anyone else in Michigan who has similar job duties to you?
A Not in Michigan.
Q Not in Michigan. Is there anyone, besides you, who works in Corizon's utilization management department in Michigan?
A I have a nurse, I have a nurse, part-time, out of Missouri, and I have two data entry secretarial-type

positions.
Q Okay. Is the nurse's name Lori Minor?
A Yes, it is.
Q What does Lori Minor do?
A She evaluates InterQual and makes sure that I have the information that I need in the request.
Q What is InterQual?
A Where is InterQual?
Q I said -- I'm sorry, what is InterQual?
A It's a system for looking at medical necessity.
Q Is it a computer system?
A It's a computer program.
Q Is there a search bar in this computer program?
A I've never used it.
Q You've never used it.
A I only look at the results.
Q I see. So what do the results show you?
A Whether it meets InterQual or not.
Q So an InterQual review would say, given this patient's data and their symptoms, this procedure or test is medically necessary or not medically necessary?
A Says InterQual met or InterQual not met.
Q InterQual met or InterQual not met.
A That's it.

Q Do you -- and how is that information transmitted to you?
A It's typed on the request and sent to me by Lori.
Q All right. So everything you need to make your decision is contained in the request form?
A Everything that I need to make the decision is supposed to be in the request form. That's a big difference.
Q All right. If I say the words "Abbreviated Review List," do you know what that is, within the context of utilization management?
A Yes.
Q What is the Abbreviated Review List?
A It's a list of procedures and requests that can be approved by the nurse. If it meets specific criteria, it can be approved.
Q What is the purpose of the Abbreviated Review List?
A Expedite answers to specific requests.
(Papendick Deposition Exhibit No. 1 was marked for identification.)
Q Okay. I'm going to show you a document. Can you see that?
A Yes.
Q Okay. We're going to go down to --
A That's very old.

Q The document I'm showing you, it's very old; is that what you said?
A It's 2016. What is it you wanted me to look at?
Q So I want to direct your attention to this page and the second sentence of the first paragraph.
MR. SCARBER: I'm sorry, Ian, what page are you on?
MR. CROSS: Page 29.
MR. SCARBER: Of the records? Okay.
MR. CROSS: Oh, are you looking for the Bates number?
MR. SCARBER: Yeah.
MR. CROSS: 29.
MR. SCARBER: Okay. Thank you.
BY MR. CROSS:
Q Okay. "These services will be subject to review by utilization management nurse reviewers based on a limited set of criteria developed by the physician reviewer team." Are you part of the physician reviewer team?
A Yes.
Q What is the limited set of criteria that your team developed for Abbreviated Review List requests?
THE WITNESS: No idea what this has to do with this case.

A This is -- for example, pacemakers have to be every six months.
BY MR. CROSS:
Q Okay.
A So that's the limited criteria.
Q So is it fair to say that if a request is on the Abbreviated Review List it doesn't come to you?
A Correct.
Q Okay. Why is biopsy of vocal cord lesion on the Abbreviated Review List?
A 'Cause a vocal cord lesion has been seen by an ENT has to be biopsied. It doesn't matter what I think or my input whatsoever.
Q You just know that that's something that always needs to be done.
A The entire corporation knows.
Q Okay. I'm going to move us up to page, I believe it is 19. Do you recognize this document?
A Not offhand, but. . .
Q Well, it was produced in discovery by Corizon, so we're going to talk about it. What is the Patient Centered Care Tracking List?
A It's a list of things that the nurse can do nothing about and needs to come to me, it's called the T-list.

Q The T-list. What's the purpose of the T-list?
A It's how the system has worked since I started in 2014.
Q It says here that the ARL and T-list are updated annually, as needed. Do you participate in updating the list?
A I don't believe I ever have. I have the Abbreviated Review List, but not the T-list.
Q Okay. Why does certain services on the T-list not require InterQual review?
A Anything that has InterQual review is reviewed.
Q So if a request comes in for a service that is neither on the Abbreviated Review List nor the T-list, what happens to that request?
A It's sent to me with an InterQual statement.
Q Okay. Is that the way it was always done?
A Yep. Yes.
(Papendick Deposition Exhibit No. 2 was marked for identification.)
Q All right. I'm going to show you another document, call this Plaintiff's Exhibit 2. It was filed in a case called Lashuay versus DeLine, and it is, or at least appears to be, an older version of the same policy from 3-1-2014. Do you know if there was a version of this policy issued between 3-1-14 and

10-1-17?
A No, I do not know.
MR. SCARBER: I'm just going to place an objection to relevance, it seems to -- to the extent that this is a policy from another case or another time period.
BY MR. CROSS:
Q So I want to direct your attention to No. 3, that sort of third Corizon logo down there; it says, "For services not included in Pass through list or T-list apply the following: If InterQual criteria are met, approve and send authorization back to site," or "If InterQual criteria is not met refer to RMD for determination." Do you know what RMD stands for?
A Regional medical director.
Q Does the regional medical director review requests for off-site service in Michigan?
A Not anymore, that's an old policy.
Q Do RMDs in other states review requests for off-site service?
MR. SCARBER: Foundation and relevance. Go ahead, if you know.
A We have three RMDs and a state medical director, all the other states have a RMD. So, yes, RMDs do, but utilization management is being utilized in every state.

BY MR. CROSS:
Q So it appears that, under this older version of the policy, if InterQual criteria were met for a service that was not on either the Pass through list or the T-list they can be authorized without physician review.
A Only if it's on the ARL.
Q Only if it's on the ARL. So that was never the case, in your experience in Michigan, that --
A What was never the case?
Q It looks like there are three buckets that a request can fall into under this old version of the policy; would you agree with me?
MR. SCARBER: Can you scroll down to the second page so we can see if there's something else down there. Okay, go ahead, I got you.
BY MR. CROSS:
Q So under No. 3, the request could be on the Abbreviated Review List or it could be on the T-list or it could be on neither list?
A Frankly, we don't see whether it's on a T-list or any list, we only see that it's InterQual criteria are met. InterQual criteria are recommendations for care.

Q So are you saying that in 2014, when you started doing this, this policy did not reflect the practices of the organization in Michigan?
MR. SCARBER: Just going to place an objection to foundation. Go ahead.
A I started in January of 2014. I don't know what was going on before I got there.
BY MR. CROSS:
Q So, I want to point out that the date of this policy or the revision date was 3-1-14.
A That was a corporate revision. I wasn't working for corporate at the time.
(Papendick Deposition Exhibit No. 3 was marked for identification.)
Q Okay. I'm going to show you what we've marked Plaintiff's Exhibit 3, the job description for utilization management medical director. Could you read the second sentence of the first paragraph, for the record.
MR. SCARBER: Ian, and I don't want to interrupt, but I'm on the side of the computer, so if you could just tell me what the pages are, that way I can kind of look along with him. 318? 618, I'm sorry.
MR. CROSS: 618.

A Could you go back to the top so that I can read it?
BY MR. CROSS:
Q Yes, of course.
A "He or she will utilize InterQual reviews as provided by Corizon Health's utilization management nurses along with Corizon Health's standard medical guidelines to determine whether a request will be approved as an off-site encounter or if an alterative treatment plan should be employed."
Q What are Corizon Health's standard medical guidelines?
A Depends on --
MR. SCARBER: I'll object to foundation, but go ahead.
A What year?
MR. SCARBER: 2017 through '18.
BY MR. CROSS:
Q It appears that the last revision was 11-3-16 for this document. But what are Corizon Health's standard medical guidelines?
A We use up-to-date and NCCN guidelines for evaluation of medical necessity, and, again, up-to-date recommendations only.
Q Are there any Corizon proprietary medical guidelines that you also use?

A Yes.
Q Do you have access to those guidelines?
A No.
Q Where are those guidelines contained?
A I don't have a clue. My brain.
Q How did you learn what the standard medical guidelines were?
A Well, which one are you talking about? If you want to talk about HTV --
Q I'm talking about the Corizon medical guidelines, not InterQual or the cancer guidelines.
A I don't understand this.
MR. SCARBER: I'll just place an objection; to the extent that you are referring to a particular policy -- and I know we gave you a bunch of documents -- I just ask that you would show whatever the document you're referring to to the witness. I doubt if he's memorized the particular areas of where the policies might be or whatever the definitions are.
BY MR. CROSS:
Q Dr. Papendick, did you testify that Corizon health had proprietary internal standard medical guidelines?
MR. SCARBER: Are you talking about

today did he testify to that or are you asking him has he testified previously?
BY MR. CROSS:
Q I'm asking if he just testified to that five minutes ago.
MR. SCARBER: Okay.
A Yes. And then you refused my answer.
BY MR. CROSS:
Q I'm sorry, would you like to say your answer again?
A Certainly. If you're talking about Hepatitis C and cirrhosis and the need for six-months' ultrasounds, that is a policy we have. If you're talking about hernia repair in patients who have pain or danger of incarceration, yes, we have a policy about that. But I don't know what you're even wanting me to discuss.
Q Okay.
MR. SCARBER: Object to form.
(Papendick Deposition Exhibit No. 4 was marked for identification.)
BY MR. CROSS:
Q I'm going to show you another document. This is a transcript of a deposition that you gave in Wright V Corizon Health. We're going to go to page -- do you remember this case at all?

A No.
Q I want to direct your attention to line six; you said, "Yes, it was in the provider handbook."
A Okay.
Q Line seven through ten, I believe you indicated that the provider handbook contains information that providers need to supply care the way the State of Michigan and Corizon wants it supplied. Do you recall saying that?
A No.
Q Are you aware of a provider handbook?
A Yes.
Q Do you have access to the provider handbook?
A Not at this time.
Q If you wanted to obtain the provider handbook, how would you go about doing that?
A It depends on if you're talking about Corizon provider handbook --
Q Yes.
A -- or a --
Q Or a, what?
A Quality Correctional Care of Michigan, PC, provider handbook.
Q Oh, so there are two provider handbooks.
A Well, I would assume so.

MR. SCARBER: I'll just object that the question may be taken out of context. I don't know what specific question this answer is in response to. We're only looking at an answer and not really the whole sequence of the questions as to what it's talking about. So I think the doctor may be speculating a little bit without having all that background; so, object to form, calls for speculation as well.

BY MR. CROSS:

Q So at line 12 -- 11, 12, you said predominantly Corizon generates the provider handbook, or this provider handbook, the one that was being discussed in this deposition?

A I don't recall.

MR. SCARBER: Same objection. Which provider handbook is being discussed in the deposition? You haven't identified that.

BY MR. CROSS:

Q Well, Dr. Papendick, why don't you tell me about all of the provider handbooks that you are aware of.

MR. SCARBER: I'll just place an objection as to form and relevance.

BY MR. CROSS:

Q You may answer.

A I know there is a Corizon health handbook.

Q What is it called?

A I believe it's called the Corizon Health Provider Handbook.

Q Okay. Have you ever seen the Corizon Health Provider Handbook?

A Years ago.

Q Did you read it?

A 2014 -- no, 2012.

Q 2012.

A When I was a provider.

(Papendick Deposition Exhibit Nos. 5 and 6 were marked for identification.)

Q Okay. I'm going to show you another document. Does this document look similar in it's content to that provider handbook?

MR. SCARBER: Can you identify the document, for the record.

MR. CROSS: For the record, this is the PIP manual from Weinberger V Corizon, recently produced by defendant Corizon.

MR. SCARBER: You're talking about the case from Missouri?

MR. CROSS: Yes.

MR. SCARBER: Okay.

A All right. I don't know what this is. What's the date on this? 2007, isn't it?

BY MR. CROSS:

Q Yeah.

MR. SCARBER: So we'll object to relevance; different case, different time period.

BY MR. CROSS:

Q All right. How about this one?

MR. SCARBER: What's your question?

BY MR. CROSS:

Q Does this look like the provider handbook that you read in 2012?

A No idea.

Q Okay. So what are your options in responding to a request for off-site treatment?

A Approve, ATP defer, need more information. I think that's the only three.

Q What is ATP?

A ATP is an alternative treatment plan.

Q Are you allowed to deny a request without issuing an alternative treatment plan?

A I don't deny.

MR. CROSS: Court reporter, could you read back that last question.

(The last question was read back.)

MR. SCARBER: Wait. There's no question.

BY MR. CROSS:

Q Could you answer that question, please.

A I don't --

MR. SCARBER: I'm going to object to asked and answered, but go ahead.

A I don't deny anything.

BY MR. CROSS:

Q So are you allowed to defer a request without issuing an alternative treatment plan?

A No.

Q Why not?

A Because that's what alternative treatment plan is all about. How can I defer it if I only have three choices: Approval, ATP, or need more information.

Q When do you respond with need more information?

A When I need more information. I do "NMI:" and tell them what I need.

Q Okay. Do you look in the medical records to find more information?

A I do not. Most of the time I don't have access, and anyone else, who is in the group doing my job, does not have access. So all the information must be in

the request.
Q Do you ever communicate with your colleagues while you are deciding how to respond to a request?
A No.
Q Never?
A Very rare.
Q In what circumstance would you do that?
A Typically if I'm working on a request from a different state and I need to know that state's procedures.
Q Under what circumstances do you issue an ATP rather than approving a request?
A When there's no medical necessity demonstrated.
Q Do you ever issue ATPs rather than approvals based on a cost consideration?
A Absolutely not.
Q In the context of your job, how do you define medically necessary?
A Medically necessary is when it will do harm if you don't do it, if the patient is in significant pain, if there is no reason to do the test or do the procedure.
Q So if there's no reason to do the procedure, it's medically necessary to do it?
A That's what medical necessity means, it is necessary

to do it. So if there is no necessity, then it is not medically necessary.
Q Okay. So, I want to go back to the definition; you said if they're in significant pain. What else did you say?
MR. SCARBER: Just going to place an objection as asked and answered.
A If not doing it will harm the patient physically, have to have medical necessity supplied by the provider.
BY MR. CROSS:
Q Have to have medical necessity supplied by the provider? What does that --
A Correct. Okay, if something is not necessary medically, it should never be asked for, there should never be a request for it.
Q I understand. Thank you.
A So the provider has to convince me that there's a medical necessity for what he is requesting, he or she is requesting.
Q Okay. Has the definition of medical necessity that you use changed at all since you started doing utilization management in 2014?
A Very little.
Q How has it changed?

A I should probably say no, because it really hasn't.
Q It has not.
A No.
Q Are there any procedures or types of requests that you are approving as medically necessary, when you started doing this in 2014, that you would not approve as medically necessary today?
MR. SCARBER: Just going to place an objection to the overbroad nature of the question, form, relevancy.
A If there was no medical necessity in 2014, they'll be no medical necessity now.
BY MR. CROSS:
Q Do you apply the same definition of medical necessity when you're covering for other UMMDs in other states?
A Yes.
Q So if you are covering in Missouri, and, hypothetically, there was a request for a reversal of a functional colostomy, would you approve or ATP that request?
MR. SCARBER: Just going to place an objection to the form of the question; it's a hypothetical without any sufficient facts to allow the doctor to really be able to answer what the

medical provider actually put in the request, what the patient's condition was, what underlying problems that the patient was facing, and things of that nature, so objection.
MR. CROSS: I'm going to object to your speaking objection.
MR. SCARBER: Object to form; object to vague and broad nature of the question.
BY MR. CROSS:
Q You may answer.
A Please repeat the question.
Q You know what, I'll move on. I'm going to give you a series of hypothetical requests for off-site services and I want you to tell me if, in your opinion, each requested service is medically necessary.
First, a 39-year-old male presents with androgenetic alopecia; the condition causes him emotional distress; the 407 request seeks an off-site consult for a hair follicle transplant; is that medically necessary?
MR. SCARBER: I'm just going to place an objection to the, still, the vagueness of your hypothetical, it's an improper hypothetical, it has nothing to do with the particular issue in this

case; objection, relevance.
BY MR. CROSS:
Q You may answer.
A On its face, no.
Q How come?
MR. SCARBER: Same objection. If you feel like you've got enough facts to answer, go ahead.
A Well, I don't have enough facts to make a permanent answer. I can tell you that the State of Michigan does not allow cosmetic care.
BY MR. CROSS:
Q What other facts would you need to make an answer?
A Something that takes it out of cosmetic care.
Q What is cosmetic care?
A Cosmetic care is a procedure that is only being done because it looks better.
Q I see. So if you got a request like that, would you recommend Finasteride as an ATP?
A I don't have anything to do with that.
MR. SCARBER: Same objection.
BY MR. CROSS:
Q What would you be your ATP if you got that request?
A My ATP would be medical -- ATP, medical necessity not demonstrated at this time, follow in on-site

clinic.
Q Okay. Same scenario, but the emotional distress causes the patient to engage in self-injurious behavior; does that change your answer?
A Medical necessity not demonstrated at this time, consult psychiatry.
Q Okay. Next, a 74-year-old female patient has a very dense cataract in the right eye, but has good vision in her left eye; request seeks cataract extraction with lens implant in the right eye because her vision is extremely poor on the right.
MR. SCARBER: I guess I'm going to object to the nature of all the hypotheticals as being not relevant, not providing enough information to the doctor to be able to really answer the question, and it calls for speculation.
A My providers know the answer to that question. They would not send it to me without the information that I need.
BY MR. CROSS:
Q So what information would you need?
A I would need to have the visual acuities in both eyes, I would have to have a list of medical problems and medications, which you have not supplied.

Q Okay. So under what circumstances would you approve that request, in terms of the visual acuity in each eye?
MR. SCARBER: I'm going to place an objection to relevance, foundation; and I'm also going to place an objection to prejudice because I think this is getting out -- getting to the point where you're raising specific issues and other inmates may be trying to seek these particular conditions and now you're going to be trying to use Dr. Papendick's speculation and guess as to whether or not somebody will get something under a specific hypothetical set of circumstances. So now you're getting into the safety of the Department of Corrections with these questions at this point.
BY MR. CROSS:
Q You may answer.
MR. SCARBER: If you feel you can answer the question.
A Not with the information I've been given, I cannot answer the question.
BY MR. CROSS:
Q So your response would be NMI, need more information?
A Absolutely.

Q And you would request the visual acuity in each eye. So, say, the visual acuity is 20/30 in the good eye and 2600 in the bad eye.
A Okay, it's still not enough information.
Q What else do you need?
A Medication list and medical conditions.
Q Assume no relevant medical condition and they're not on any medication.
MR. SCARBER: (Audio disruption.)
THE COURT REPORTER: Excuse me, what was the objection?
MR. SCARBER: I'm sorry, I said same objection.
A Give me the old ophthalmology note. You're not giving me any information.
BY MR. CROSS:
Q All right. A 53-year-old male has a history of hearing loss since ten years ago; the patient experiencing difficulty discriminating voices; the patient previously used hearing aids, which significantly improved hearing loss; patient can perceive a whispered voice and finger rub in his right ear but not in his left ear; he can hear a person talking in a quiet room; the request is for an audiogram evaluation for hearing aids.

A And your question?
Q And my question is, would you consider that medically necessary?
A Yes.
Q Yes?
MR. SCARBER: I'm still going to place an objection to the form of the question, as well as the relevancy to this particular issue, as well as any potential safety concerns in the Department of Corrections regarding inmates who are trying to get procedures.
BY MR. CROSS:
Q Why is it medically necessary?
MR. SCARBER: Object to a misstatement of the witness' answer.
BY MR. CROSS:
Q I'm sorry. Did you say yes or no, sir?
A It will be approved.
Q Why would it be approved?
A Because the McBride settlement with the State of Michigan require it.
Q A 30-year-old male patient injured his back six months ago while doing heavy lifting during a prison work assignment; he complains of continuous lower back pain; the patient is able to walk, but is not

able to play sports or do his previous prison job; he also reports numbness and weakness in his right leg; he recently had an MRI, which shows disc herniations with nerve root impingement at L4 to 5 and L5-S1; request is for epidural steroid injections.
THE WITNESS: I'd like to know where he got these cases.
MR. SCARBER: What's your question? I'm still going to object to unfair hypothetical and for all the other prejudicial reasons I said, but what's the question?
BY MR. CROSS:
Q Would you approve that request or issue an ATP or need more information?
A It would not be approved. I do need more information.
Q Why wouldn't it be approved?
MR. SCARBER: Same objection.
A There's not enough information supplied.
BY MR. CROSS:
Q So what additional information would you need and how would that information determine your decision?
A I need a diagnosis.
Q Okay.

A And if it was a surgical diagnosis it would go to neurosurgery before it went to whoever they were gonna send it to for an injection.
Q 25-year-old male with no significant comorbidities had part of his left ear severed in a fight with another inmate; the patient's wound is bandaged, he has normal vitals, and he is hemodynamically stable; the on-site provider has placed the ear on ice; urgent request to send the patient and ear to the hospital to attempt to reattach the ear. Approve or ATP?
MR. SCARBER: Same objection; form, unfair hypothetical, calls for speculation, not relevant.
A So your question is? Evidently we've lost sound.
MR. SCARBER: I think he's pausing.
BY MR. CROSS:
Q So approve or ATP? That's the question.
A Neither one.
Q Neither one?
A Correct.
Q What would you do instead?
A I would never receive this. This patient would automatically go to the emergency room to be evaluated and treated, it would never come to me.

Q All right. A 55-year-old male patient has been incarcerated for 30 years; his earliest release date is five years away; the patient has a colostomy established ten years ago in management of acute diverticulitis; request authorization of a general surgeon consult for consideration of colostomy reversal.
A Not enough information.
Q What other information do you need?
A I need to know if there's any complications of him having a colostomy at this time.
Q And how would that information help you make a decision?
A There are dangers, risks, to having surgery, and the only thing that a surgeon will do for this patient is do surgery. So there is no reason, no medical reason, to send him to a general surgeon if the risk outweighs the benefit.
Q I see. So let's change the question a little. Let's say the patient has a disease that, if not promptly treated by a specialist, could result in the eventual loss of the patient's colon and rectum and the need for a permanent lifetime ileostomy. Would off-site treatment to prevent that outcome be medically necessary if the patient would be able to

complete activities of daily living and have no problems with the ileostomy bag after the eventual removal of their colon and rectum?

A I would say I don't have enough information.

Q You don't have enough information.

A No.

MR. SCARBER: And I'm going to place an objection to the question, as well, because you're presuming some of these potential risks that could happen to the patient if he didn't have the ileostomy, or whatever the other medical condition is here.

I haven't seen anything from any doctor talking about what the other person needed or nor has this particular doctor or witness here that you're asking a question about at this particular time. So calls for speculation, foundation, relevance, and, again, I think this is starting to get -- starting to border on you trying to represent other patients or inmates in this particular case, which is objectionable, and we'll move to strike some of this line of questioning. It's one thing to try to show that there is some type of Monnell claim, but now you're getting -- I think you've gone beyond that.

BY MR. CROSS:

Q When is the last time you performed a colostomy take-down surgery, if ever?

A Did it in medical school 30 years ago.

Q Would you agree that the risks associated with surgery vary from patient to patient?

A Certainly.

Q Would you agree that a general surgeon who sees the patient for a consultation would be in a better position to evaluate the risks and benefits of the surgery than you would?

A Not enough information.

Q What other information would you need?

A I'd need to know the number of cases that the surgeon has done.

Q All right. So if the surgeon has done at least 100 take-down procedures in their career, colostomy take-down procedures in their career, could you answer the question then?

MR. SCARBER: I'm going to place the same objection, that it doesn't -- the hypothetical doesn't provide enough information and it has no relevancy to Mr. Jackson.

BY MR. CROSS:

Q Go ahead.

A I don't recall the form of your question. Could you please reask your question.

MR. CROSS: Can you read the question back.

(Page 43, lines 16-19 were read back.)

A And the question is?

BY MR. CROSS:

Q Would you agree that a general surgeon who sees the patient for a consultation would be in a better position to evaluate the risks and benefits of the surgery than you would?

A No.

Q No? How come? Do you have an answer, sir?

A I have several answers.

Q Let's hear them.

A You're not hearing all of them. You're hearing one of them.

MR. SCARBER: (Audio disruption).

THE COURT REPORTER: Excuse me, could you repeat that, Mr. Scarber.

MR. SCARBER: I'm sorry, I asked the doctor do you have enough information? Do you need more information? Are you able to answer the question.

A I need more information.

BY MR. CROSS:

Q What other information do you need?

A Outcome. He may have done 100, but if 99 of them had complications, do you have that information? Do most physicians have that information? No.

Q Do you? Do you learn about the general surgeon's experience and the outcomes of their previous surgeries before you make a decision on a 407 request for a consultation with a general surgeon for colostomy reversal?

MR. SCARBER: Going to place an objection to relevance in this particular case, doesn't seem to have anything to do with Mr. Jackson's case, and you haven't put in context the general surgeon's involvement with the particular inmate, when that involvement occurred or anything of that nature. I'm going on without trying to make a speaking objection, but I think I'm just trying to lay the foundation that there's clearly not enough facts here for this witness to be able to answer the question without it being placed in the proper context. If you can answer his question, go ahead, I made my objection.

A Yeah, there's just no way to answer what he's

asking.
BY MR. CROSS:
Q I'm asking if you evaluate the surgeon's experience and success rate when you decide whether or not to approve a consult with that surgeon when you're doing your job?
MR. SCARBER: I'm sorry, was there a particular consult in this case with respect to Mr. Jackson? I'm going to object to relevance.
MR. CROSS: Devlin, you asked my client about his sex life.
THE WITNESS: I did?
MR. CROSS: You didn't, your attorney did.
MR. SCARBER: Mr. Jackson's sex life was all throughout the records, throughout his medical records, and it had to do with what his damages were. They were in his own records before and after the -- before and after he went to jail.
MR. CROSS: All right.
MR. SCARBER: So, clearly, your client's medical records are relevant. What you're asking this particular witness is a hypothetical about what he would do about evaluating a particular surgeon if the surgeon needed a consult.

BY MR. CROSS:
Q I'm sorry, I'll be clearer. I'm not asking you a hypothetical question, sir. I'm asking you when you review these requests for a surgical consult for colostomy reversals while doing your job -- for example, the request you reviewed for my client -- did you learn about the success rate of the surgeon before you decided whether or not to approve the consult?
MR. SCARBER: I'm going to place an objection because it's still not relevant. There was no surgical consult requested for a particular surgeon in this case. There was a request made for a colostomy reversal. So, relevance and outside of the facts of the case.
BY MR. CROSS:
Q Do you get annual performance evaluations at your job, sir?
A I'm assuming so. We get a decision on pay raise or not.
Q So you're not aware if you get annual performance evaluations?
A It depends on what you would call a performance evaluation. If you're talking about how long it takes me to turn around a case, yes. There is

nothing specific to a case.
Q Is a portion of your annual performance evaluation based on the percentage of requests that you ATP?
A No.
Q It's not.
A No.
Q So your ATP rate has no effect on how your performance is evaluated?
A No, it's reported, not evaluated.
Q Has it ever been evaluated?
THE WITNESS: Can we stop a minute?
MR. SCARBER: Yeah, let's take a -- there's a question on the record and I don't want to stop you from getting the answer to your question, but after you do I want to take a quick break. I just want to --
MR. CROSS: Sure.
MR. SCARBER: Yeah.
BY MR. CROSS:
Q Can you answer the last question and then we'll take a break?
A No, I cannot.
Q You cannot answer that question?
A No.
MR. CROSS: Can you read the question

back, ma'am.
(Page 48, lines 7, 8 and 10 were read back.)
A No, it has never been evaluated in performance -- or enumerating my performance.
Q Okay. Thank you. Do you want -- how much time would you like?
A Five.
Q Five? All right. Why don't we take ten.
A I'm good with five.
THE VIDEOGRAPHER: We're going off the record at 11:36 a.m.
(Break was taken.)
THE VIDEOGRAPHER: We are back on the record at 11:51 a.m.
MR. SCARBER: Ian, Attorney Devlin Scarber here. I talked with the doctor afterwards, after our break, and I think he was having a misunderstanding about what you were saying. So I'm going to let him -- he wants to discuss his prior answer with you, or at least explain it.
MR. CROSS: To which question?
MR. SCARBER: You asked him a question about his ATPs or something about what's a part of his job review or something like that.

BY MR. CROSS:
Q All right. Dr. Papendick, now that you've talked to your attorney, what do you want to tell me about your ATPs and your job review?
A There is a job review form that is put out by the supervisors to us, and it does so that there is a scale for the percent ATPs and other items. So there is an evaluation made of our abilities, of our performance, but it has nothing to do with how much I make.
Q Okay. So there's a performance evaluation, but it doesn't factor into your pay, is what you're saying.
A That's correct.
MR. SCARBER: Explain.
A I rarely get an increase in pay. I haven't had one in four years, I got one this year, and I think I got one last year. But I haven't had an increase in pay in years. And so, yeah, it looks like it is. But when your increase in pay is two percent, essentially the cost of living, it's hardly a significant increase in pay. Also, the ATP rate is generic, it has absolutely nothing to do with specific ATPs.
BY MR. CROSS:
Q Okay. I'm going to show you another document -- by

the way, did you take the opportunity to review any documents during the break, sir?
A No.
Q No. Okay.
A Well, we looked at the fact that there was an evaluation form.
Q So you've reviewed the evaluation form?
A Correct.
Q Okay. Did you review any other documents?
A I don't think so, no.
Q Okay. Let me bring up another document. Can you see it?
A Yes.
(Papendick Deposition Exhibit No. 7 was marked for identification.)
Q This is what we will call Plaintiff's Exhibit 7, deposition of Keith Papendick in Spiller V Stieve. Do you remember that case?
A Names.
Q Okay. I want you to read, for the record, lines 13 through 17, that question and answer.
A Okay.
Q "Has anybody ever sat down with you, talked about your cost per thousand patients? Has anybody ever sat down with you and had discussions about your

cost per thousand patients being too high"? And you said, "No, it's not. I'm not the highest. I'm not the worst." Who are the other people that you are comparing yourself to in that answer?
A I don't recall.
MR. SCARBER: Hang on, I'm just going to place an objection to form, because it was a couple of questions that you asked. But you want him to answer the last question?
MR. CROSS: Yes.
A Okay. I have no idea.
BY MR. CROSS:
Q You don't know who those people you are comparing yourself to in that answer are.
A No, it was sometime ago.
Q So, let me ask you the question again today. Has anybody ever sat down with you, talked about your cost per thousand patients?
A Never have I been told what my cost per thousand patients is. And, by the way, it's cost per thousand patients year, is how --
Q Cost per thousand patients, what was that, I'm sorry?
A Year, over a year.
Q Over a year. Okay.

A And it's not just cost per thousand. And, no, I have never talked with anybody about my cost per thousand.
Q Did you say that you don't know what your cost per thousand is?
A I do have no clue.
Q All right. I want you to read, for the record, lines 21 to 23 of this deposition transcript aloud.
A "Has your cost per thousand patients gone up or down since you've been there"?
"It originally went up and malpractice cases went down. The number of malpractice cases filed went down and they attributed that -- they attributed the end" --
Q Well, that's fine. So based on your answer, it sounds like, at the time, you knew how your cost per thousand patients had changed over time.
MR. SCARBER: I'm just going to place an objection; calls for speculation and foundation.
BY MR. CROSS:
Q Did you know that at the time?
A I did not know at the time what my cost per --
THE WITNESS: I already told him this.
A I have never discussed cost per thousand.

BY MR. CROSS:
Q So then why did you say, "I'm not the highest. I'm not the worst"?
A I already told you I don't recall saying that and don't remember why.
Q Okay. Why did you say, "It originally went up and malpractice cases went down"?
A Because my ATP rate -- my ATP rate, in the first month I was there in 2014, went down; in other words, I had more approvals than I did ATPs; thus, there were less malpractice cases, and so we knew that we were spending more on outpatient, but I don't know what the numbers are.
Q So you don't know the number that is spent, but you know your ATP rate?
MR. SCARBER: I'm just going to place an objection; mischaracterizes his answers.
MR. CROSS: I'm asking him to clarify.
A When your boss comes to you and says your ATP rate has gone down, meaning you're approving more --
BY MR. CROSS:
Q Um-hum.
A -- what am I to know?
Q What do you mean by that?

MR. SCARBER: Same objection; form, relevance.
THE WITNESS: I already answered.
BY MR. CROSS:
Q Who is your boss?
A Right this minute?
Q No, at the time when they told you that your ATP rate had gone down.
MR. SCARBER: I don't think he ever said anybody told him that. I'm sorry, mischaracterizes his testimony. I think he was giving you a hypothetical, but mischaracterizes his testimony.
A My boss at -- I'm not sure.
BY MR. CROSS:
Q You don't know?
A No, that's not what I said. I said I'm not sure. It could be one of two people.
Q And who are those two people?
A Jeffrey Bomber and Erin Orlebeck.
Q When you said malpractice cases went down here, on line 23, were you referring specifically to state law medical malpractice claims or were you also including Eighth Amendment claims, like the one we're here for today?

A The Eighth Amendment claims started later in my time with Corizon.
Q What do you mean by started later?
A We weren't getting Eighth Amendment claims in January of 2014.
Q So nobody sued Corizon for violating their Eighth Amendment rights in 2014; is that your testimony?
A I don't know of any. Most of the Eighth Amendment claims came later.
Q So --
MR. SCARBER: I'm just going to place an objection to foundation also. I don't know how he would possibly know how many cases were being filed or who was being sued against Corizon, but. . .
BY MR. CROSS:
Q Well, how do you know that, sir?
A How do I know what?
Q You know the volume of claims filed against Corizon.
A I do not know the volume of claims filed against Corizon.
Q Well, you just testified that the Eighth Amendment claims came later, and you testified here that the malpractice cases went down. So it sounds like you have some knowledge of the volume of claims.

A No, I do not.
Q No?
A No. I just told you that twice now.
Q Okay. Do you know what InGauge is?
A InGuage. No.
Q InGauge.
THE COURT REPORTER: What was that?
A Don't know either.
THE COURT REPORTER: Mr. Cross, what did you say?
MR. CROSS: InGauge, I-n-G-a-u-g-e.
A InGauge?
(Papendick Deposition Exhibit No. 8 was marked for identification.)
BY MR. CROSS:
Q Yeah, I don't know how to pronounce it.
A The program is no longer used, that I know of.
Q I'm going to show you another document. Have you ever used a program that looks like this?
A I have never used a program that looks like that.
MR. CROSS: For the record, this is Bates 460.
BY MR. CROSS:
Q You said it was no longer in use, that you know of?
A That I know of.

Q Okay. Do you know what a KPI is?
A No, not a clue.
Q Did you ever receive any training from Corizon about KPIs or --
A I don't know of it.
THE COURT REPORTER: "Or," what was the last?
BY MR. CROSS:
Q Key performance indicators.
A No.
(Papendick Deposition Exhibit No. 10 was marked for identification.)
Q All right. I'm going to show I another document, Bates 266. This was produced in discovery. Do you recognize any of these training modules?
A That was eight years ago; no, I don't remember.
Q But you did complete this training, correct?
A Obviously.
Q And then there's a module here called "Key Performance Indicators, slash, Profit Indicators"?
A I can't recall that.
Q You don't remember anything about that training.
A No.
Q Do you remember if the training was done on a computer?

A I don't recall even doing it. How would I know to recall if it's on a computer? Oh, I'm sorry, I'm not supposed to ask questions.
Q That's all right. Back to exhibit -- I want to go back to this document. In your time working in utilization management, have you ever looked at a graph similar to this one that shows a benchmark and a line representing an actual value?
A For inpatient days, no, I have nothing to do with inpatient days.
Q Well, what about referrals?
A I don't recall this. It's InGauge, I told you I don't recall it.
Q I'm asking you if you have ever seen a graph that looks similar to this one, whether InGauge or anywhere else, with a benchmark and a line showing the actual value?
A No, I don't believe so.
Q No? Okay.
MR. SCARBER: I think he said I don't -- "No, I don't believe so,"' that was his answer.
THE COURT REPORTER: Excuse me, Mr. Scarber, can you repeat that.
MR. SCARBER: I said I think his answer was "No, I don't believe so."
A And I will verify that is my answer.
BY MR. CROSS:
Q All right. See on this page, they have an abbreviation here, PMPM? Do you know what that stands for? PMPM by primary category, for example? What is PMPM?
A In the insurance days, when I was in private practice, PMPM meant something. I don't recall. Per member per month.
Q Per member per month. Okay. And is the value in that -- strike that. Do you have a target value for your ATP rate, sir?
A No.
Q Does anyone in Corizon have a target value for their percentage of off-site requests approved, that you're aware of?
A No.
Q No? Okay.
MR. SCARBER: Answer the question?
THE WITNESS: I did.
MR. SCARBER: Once you answer the question you don't have to go back and --
THE WITNESS: I know.
MR. SCARBER: Okay?

THE WITNESS: I was going to explain, but I don't need to.
BY MR. CROSS:
Q Could you explain, say what you were going to say.
MR. SCARBER: Was it responsive to the question or was it --
THE WITNESS: It's responsive to the question.
MR. SCARBER: All right.
A If you have no clue what requests are coming to you on a daily, weekly, monthly or yearly basis, how can you set up a percent ATP gauge? You can't, you just can't. And if you can, you need to be, in medicine, giving that information to a medical community.
(Papendick Deposition Exhibit No. 9 was marked for identification.)
BY MR. CROSS:
Q All right. I'm going to show you another document, call this Plaintiff's Exhibit 9. You recognize this document?
A It's a CV printed by Corizon.
Q Okay. I want to direct your attention to the "Key Accomplishments" section. Can you read your first key accomplishment, for the record, out loud.
A "Worked with providers one-on-one and increased

approval rate for outpatient consult request to 90 percent consistently."

Q So was 90 percent a goal or target value for approval rate for outpatient consult requests for providers?

A No.

Q Can you describe what you did to achieve that key accomplishment.

MR. SCARBER: I'll place an objection to form and overbroad or vagueness of the question. But if you can understand it, go ahead.

A Teaching providers what they need to put into a 407 to get it approved.

BY MR. CROSS:

Q All right. What do providers need to put in a 407 to get it approved?

A Medical necessity.

Q They just need to -- I'm assuming they don't just need to write "medical necessity" on the form.

A That's a very good assumption.

Q So what specific things do they have to do on their form to get it approved?

A We already talked about that; did we not?

Q I'm asking you what you trained them to do in order to get their request rate above 90 percent.

MR. SCARBER: I'll just object, asked and answered, but --

THE COURT REPORTER: Excuse me, excuse me --

MR. SCARBER: I'm sorry, I've got this mask on because I'm sitting right next to the witness. But what I'm objecting to, I just objected to asked and answered, 'cause he's already explained it. But to the extent the question is different, I've asked the doctor to answer, if he can answer.

A It is no different.

BY MR. CROSS:

Q So when you worked with the providers one-on-one, how did you communicate with them?

A We talked on the phone mostly.

Q Talked on the phone? Did you send emails?

A Rarely. I hate email. They take too long to type. And I have a finger cut off (indicating).

Q It was the phone provided to you by Corizon?

A There was the phone on my desk.

Q Is that your personal cell phone?

A No, it was the phone on my desk. I don't know if it's Corizon's or if it's the company that we're renting the building from.

Q Okay. Do you work from home?

A Now or then?

Q Let's say in 2017.

A Mid-2017 I started working from home.

Q Okay. Did you ever counsel providers to limit what they submitted requests for in order to increase their approval rate?

A Absolutely not. It's unethical.

Q So you didn't counsel them to avoid requesting services that aren't medically necessary?

A That's not the same question. Please don't phrase it like it is.

Q Well --

A They were always told if it's not medically necessary, do not ask for the procedure.

Q All right. So, I'm a provider. How do I know whether or not a procedure is medically necessary?

A I've already answered that. Didn't I? Didn't I tell you what was medically necessary?

Q I think I interrupted you in the middle of your definition and I didn't get the end of it and I want to get the whole thing, for the record.

MR. SCARBER: I'm going to place an objection, asked and answered. He went through like a multistep process previously where he gave you the definition of factors to be considered for medical

necessity. But that was at -- near the beginning of the deposition.

BY MR. CROSS:

Q Well, were there any factors that you did not include in your previous answer?

A I don't believe so.

Q You don't believe so?

A Correct, I don't believe so.

Q All right. Let's go back to, this is Exhibit 1 again, and I'm going to direct your -- we're on Bates 104 and 103. What is the utilization management core process?

MR. SCARBER: I'm sorry, did you say what is it or where is it? I didn't hear --

MR. CROSS: I said what is it? What is the utilization management core process?

MR. SCARBER: Okay. If you know.

A The utilization management on a centralized basis.

BY MR. CROSS:

Q How is that different from the previous practice?

A The previous practice, the RMDs in all the states, and the SMD in Michigan, who were all Corizon employees, did all of the approvals.

Q And who did the approvals under the centralized core process?

A Utilization management medical directors.
Q When did this change take place in Michigan?
A 2017, I don't recall the date, I think it was June.
Q June 2017? All right. I want to direct your attention to this last paragraph on Bates 104 about how success of this program will be measured. What is the difference between outpatient referrals per thousand and claims per thousand?
A Referrals are what we approve in order to get the claim paid.
Q So when you -- is what do you for a living approve or deny outpatient referrals? I'm sorry --
A I do not deny outpatient referrals.
Q But do you approve or ATP outpatient referrals?
A Or I ask for more information.
Q Okay. And you are not involved in the claims portion.
A No, what I do is, but I don't.
Q What is referrals per UMMD?
A I think that's pretty much explanatory.
Q So the number of referrals you process or the number that you approve or --
A I'm not actually sure what that means. I'm assuming it's the number that we process.
MR. SCARBER: I'm going to object;

calls for speculation.
BY MR. CROSS:
Q All right.
MR. SCARBER: If he's assuming.
A I'm assuming.
BY MR. CROSS:
Q So it says, "Each state will be assigned two primary UMMDs to support objectivity and reduce the likelihood of UMMD bias." Was there another UMMD assigned to Michigan besides you?
A There are three.
Q There are three. Who are they?
A Two other are UMMDs.
Q What are their names?
MR. SCARBER: I'm just going to place an objection to relevance. But he's asked the question, I can't object --
THE WITNESS: You can't stop me from answering it.
MR. SCARBER: It's not privileged.
A Dr. Dorsey and Dr. Stacey.
BY MR. CROSS:
Q So if I was a prisoner in Michigan and a request was submitted for off-site care, it might be reviewed by you or it might be reviewed by Dr. Dorsey or it

might be reviewed by Dr. Stacey?
A Correct.
Q If there a way that the work flow is assigned between the three of you? Do you handle certain types of requests, in other words?
A It's two, one and one.
Q Two, one and one? What do you mean by that?
A I get two, they each get one.
Q Why do you get more than them?
A Because they have other states to do and my workload got so high that they wanted to put some of that on the two of the other UMMDs.
Q Got it. Were there three UMMDs in 2017?
A I don't know, but I don't think so.
Q You think you were the only one then.
A Correct.
Q So it says they're implementing a feedback loop so we can adjust as needed based on quantitative and qualitative results with 30/60/90 day review, RMD and UMMDs. Did you participate in those 30-, 60- and 90-day reviews?
A No, that's supervision.
THE COURT REPORTER: Excuse me?
A That is supervision.
Q So who did the reviews?

A I don't know. I can make an assumption, but I'm not going to.
Q Okay. Did you participate in quarterly interrater reviews of other UMMDs?
A We do a quarterly evaluation of two cases that we denied and they -- excuse me, we ATP'd, and the ATP was overturned on appeal.
Q Tell me what you do in that interrater review process, like how do you -- what's the results? What's the input?
A We look at what I -- okay, let's say we're looking at my two cases every quarter.
Q Sure.
A My two cases are evaluated in a meeting if my ATP is overturned on appeal. Is that straight?
Q Okay. And they decide, what, in that meeting?
A The appropriateness of what we did.
Q Okay.
A It's a quality control thing.
MR. SCARBER: And then I'm going to, again, object to the extent you get into more detail about the peer-review privilege, as well as the Patient Safety Quality Improvement Act.
BY MR. CROSS:
Q All right. It says they are measuring the success

of this program via outpatient referrals per thousand? How would the outpatient referrals per thousand metric indicate success versus failure?

MR. CROSS: I'm just going to place an objection to foundation. He's already said he doesn't do these particular reviews and already discussed his limited knowledge of exactly the meanings of those.

THE WITNESS: Do I answer now?

BY MR. CROSS:

Q Yeah, go ahead.

A It has nothing to do with me. This is a board of directors' report.

Q Do you have any knowledge of how success is measured --

A No, that's the point I've been making.

Q Okay. Do you submit a monthly report as part of your job duties?

A What kind of monthly report are you talking about?

Q Well, why don't you tell me all the monthly reports that you submit.

MR. SCARBER: I'm going to place an objection and I'm not going to let him continue to answer questions that you have not specified have any relation to this particular incident. So he's

not going to talk about every last thing he -- every last report he does. I mean, are you talking about utilization management? Are you talking about how many times he went to the bathroom? You know what I'm saying? I mean, you've got to put this stuff in some kind of context. It's too broad to be answered.

BY MR. CROSS:

Q I would like to know what reports you submit.

MR. SCARBER: Same objection.

THE WITNESS: Am I supposed to answer it?

MR. SCARBER: If you can answer the question and recall what you specifically; if you can't, you indicate that.

A I report a time sheet every two weeks --

BY MR. CROSS:

Q Okay.

A -- period. Nothing else. There are no more reports coming out of my computer.

Q Were there ever any other reports coming out of your computer?

A Years and years ago.

Q How many years ago?

A Eight.

Q So not in --

A No, more than that, ten, ten.

Q You didn't submit any monthly reports in 2017?

A No, I don't believe so. I was corporate in 2017.

Q In 2016 did you submit reports?

A I don't remember.

Q You don't remember if you submitted a monthly report in 2016.

A No, I don't remember. That's what I said, right?

Q Yep.

A Okay.

Q All right. Did you review any documents to prepare for today's deposition?

A Very little.

Q What documents did you review?

A Medical record. The only thing I have any access to and the only thing I need is medical record, if I had access to it, because that was about the time they were changing the medical record system. I have no access to anything prior to that time.

Q What medical records did you review?

A I don't recall. Probably an ATP.

Q Did you review a request for a surgical consult for a colostomy reversal from April of 2017 for a patient by the name of Kohchise Jackson?

A Yes, and didn't I just say that?

MR. SCARBER: Just answer his question.

THE WITNESS: Okay.

BY MR. CROSS:

Q Did you make a determination when you received that request in April of 2017?

A A determination of. . .

Q Either an NMI, ATP or approve?

A ATP.

Q Do you think you made a mistake when you issued that ATP?

A No.

Q You think you made the right call.

A Yes.

Q Why do you think you made the right call?

MR. SCARBER: Hang on one second, Ian, I apologize, the doctor's phone is ringing. Go ahead. His question was why did you make the right call.

A The danger of surgery in anyone does not depend on how sick they are or how old they are, there is a baseline question about whether its risk is worse than its benefit. His risk was more than his benefit for a colonosc -- yeah, colonos -- colostomy

reversal. He was having absolutely no complaints, except that he wanted his reversal. He was having no medical problems whatsoever, according to the provider who saw him on a regular basis.

BY MR. CROSS:

Q So you believed that the risks of the reversal surgery outweighed the benefits for Mr. Jackson?

A Yes.

MR. SCARBER: I'll place an objection to a number of the other things he just mentioned, but. . .

BY MR. CROSS:

Q Your answer is "yes"?

A Yes.

Q Okay. Are you aware that Mr. Jackson has since had a colostomy reversal surgery?

A I heard that.

Q So would you disagree with -- you think the doctor who performed that surgery made the wrong call in doing it?

A That is not my place to say.

Q Why not?

A I have no idea where he was when he had it done, I have no idea what his medical care was like, what was that, ten years later? No, three years later.

Q Do you consider or take into account in any way whether or not a procedure could be done just as effectively after a patient is released from custody?

A No, I do not. That would -- nevermind.

Q So if a patient has a colostomy bag and a life sentence, you think that they should never have it reversed, unless -- as long as the colostomy is functioning.

A If the colostomy is functioning with no issue whatsoever, yes, he should continue to have his colostomy.

Q For his whole life.

A If that's what it takes.

Q So you don't think, in general, the benefits of reversing a functional colostomy ever outweigh the risks of that surgery?

A Okay, you're asking me to answer questions that I don't get circumstances for. It all depends on the circumstances. So I can't give you an answer for a nonspecific question.

Q Well, if you need more information to make a determination, tell me what that information is and how that information would allow you to say yes or no.

A Are you trying to take over my job?

Q I'm asking the questions here.

MR. SCARBER: Let me just place an objection to form of the question; again, I think these are unfair hypothetical questions. I think you have to put all of this stuff in some kind of context relative to the patient, the presenting circumstances, the conditions of that particular patient.

A So is there a question that I need to answer?

BY MR. CROSS:

Q Yes, unfortunately. Do you think that, in general, when a patient is otherwise healthy and has a functional colostomy that is not causing other health issues the risks of reversal surgery outweigh the benefits?

A Again, comes down to the circumstance. I don't have a medical record laying in front of me in order to evaluate that.

Q So if you had a medical record, what things would you look for in it and how would those things affect your answer?

A Complications of the colostomy.

Q Um-hum.

A Breakdown -- well, that's complication of the

colostomy. Complications of the colostomy.

Q Is that the only thing?

A If there is no medical complication of a colostomy there's no reason to reverse it.

Q Are you aware that colostomies without complications are sometimes reversed?

A Absolutely. I've ordered them to be reversed.

Q Why did you order a colostomy without complications to be reversed?

A I'm sorry, I'm sorry, that's not true, they had complications. I'm sorry, I made a mistake.

Q So you think a surgeon who reverses a colostomy, when there are no complications, is exposing the patient to risks that outweigh the benefits of the surgical procedure?

MR. SCARBER: Let me just place an objection to relevance. In this particular case, we're not talking about a standard of care of any follow-up doctors, there's no malpractice claim. What we're talking about is whether there was a cruel and unusual punishment, a violation of Mr. Jackson's deliberate indifference rights. Dr. Papendick isn't here to talk about the standard of care of Dr. Weber or anybody else. He's here to talk about what was in front of him at the time he

made his decision or performed his review.
MR. CROSS: I'm objecting to the speaking objection.
BY MR. CROSS:
Q Go ahead and answer.
A What was the question again?
MR. CROSS: Can you read the question back.
(Page 77, lines 12-15 were read back.)
MR. SCARBER: Same objection, and I think this was kind of asked and answered previously a few minutes ago --
THE WITNESS: It was.
MR. SCARBER: -- but go ahead.
A First of all, I cannot judge another physician's decision-making, that's not my job. Second of all, I don't understand why this question is even being asked. I have an opinion, as anyone else, and I should be able to express my opinion.
BY MR. CROSS:
Q Can you answer the question, sir?
MR. SCARBER: I'm going to place an objection. I think he just answered the question. I think he just told you -- without restating it, he

answered the question and is, first of all, part of his answer. So, asked and answered, now going on three times.
A I've already answered this.
BY MR. CROSS:
Q Aren't you judging another physician's opinion when you issue an ATP in response to their request?
A There was no request from a physician who would be doing the procedure. There was a request from a fairly new provider in the Michigan Department of Corrections, who were employed by Corizon Health -- well, Quality Correctional Care, PC, of Michigan.
Q Now, was that request for a surgery or for a consult with a surgeon to evaluate the risks and benefits of a potential surgery?
A Consult to see the surgeon, but there was no reason to do it. There was no reason to do -- even look at a reversal if there's no complications, except to get the surgeon $350.
Q Do you think it's a trivial thing to live with a colostomy bag for the rest of your life?
A No. Did I say that?
Q No.
A Okay.
Q But don't you think there are some benefits to the

patient of being able to have normal bowel movements?
A Maybe.
Q But you believe the risks of the surgery outweigh those benefits?
A I didn't name any benefits, but I believe the risk of the surgery outweighs not reversing it.
Q Does the patient has any input on whether they're willing to assume those risks?
A No, because if he did -- if we allowed him to and he died from his surgery, I'd be sitting at this table anyway; correct or incorrect? Except then he would not be living, which is much worse than a colostomy. Even if his -- no, I won't go there.
Q Go ahead. What were you going to say?
A I don't know that, I can't say it.
MR. SCARBER: All right. He's done with his answer.
BY MR. CROSS:
Q What were you going to say?
MR. SCARBER: Was it responsive to the question or --
THE WITNESS: No.
MR. SCARBER: Okay. Thank you.

BY MR. CROSS:
Q Do you know the fatality rate for colostomy reversal surgeries?
A No. I have --
THE WITNESS: I know, I'm settling down.
BY MR. CROSS:
Q No, you don't?
A No, I don't. I already told that you.
MR. SCARBER: Ian, let's take a quick five-minute break.
MR. CROSS: All right. Sounds good.
MR. SCARBER: Thank you.
THE VIDEOGRAPHER: We're going off the record at 12:43 p.m.
(Break was taken.)
THE VIDEOGRAPHER: We're back on the record at 12:53 p.m.
BY MR. CROSS:
Q Dr. Papendick, when you issued the ATP for Mr. Jackson, did you do it pursuant to an MDOC policy?
A There is an MDOC policy that surgeries must be approved through medical necessity and, yes.
Q Yes?

A Yes.

(Papendick Deposition Exhibit No. 12 was marked for identification.)

Q Okay. I'm going to show you a document that your lawyer filed in this case. So, this policy, are you saying that you didn't approve the surgery because of this policy?

A Yes.

Q All right. Can you point out the part of this policy that you believe -- let me ask you this: Did this policy control the outcome of your decision?

A Well, if it's direct, yes. Do you want to know where it is?

Q I want to know if the policy controlled the outcome of your decision.

MR. SCARBER: Asked and answered.

A Yes.

BY MR. CROSS:

Q You said, "If it's direct, yes"; what does that mean?

A If the policy is a directive, yes. If you go down to "AA" under "Corrective and Reconstructive Services."

Q Okay. So tell me about what part of this policy you believe constrained your decision.

MR. SCARBER: Just going to place an objection to the phrasing of the question. You said it controlled his decision, not constrained it, if there's a difference.

BY MR. CROSS:

Q I'm sorry. What part of the policy controlled your decision?

A It looks like "AA" and "BB."

Q "AA" and "BB"?

A Correct.

Q So you believe that a colostomy take-down procedure is a corrective surgery or a reconstructive surgery?

A Reconstructive.

Q Okay, "a surgical procedure to reform body structure or correct defects." So, what part of "BB" controlled your decision?

A Only if determined medically necessary and if approved by the CMO.

Q So did you contact the CMO?

A No, I don't have to. I have a policy.

Q You have a policy.

A Right, that's what I just read you.

Q How can we know if the CMO approves it or not if you don't contact the CMO?

A The way the contact with the CMO occurs is if the provider decides that he wants to appeal, and then appeal is a very large process that ends with the CMO.

Q So the only way that a -- correct me if I'm wrong, it sounds like the only way that a corrective or reconstructive surgery could happen is if the request came to you, you deferred or ATP'd the request, the provider then appealed, the appeal moves through the appeals process to the CMO; am I right about that?

A In a general, a generalized step, yes.

Q What do you mean by that, in a general --

A You're not being specific.

Q Specifically, is it possible that an MDOC prisoner could receive a corrective or reconstructive surgery without you first issuing an ATP and then the provider on-site starting an appeal process and the appeal process culminating with the CMO?

A That's one way.

Q That's one way. But are there --

A If it is medically necessary, it will be done.

Q It will be done.

A Correct, and I have done colostomy reversals because they were medically necessary.

Q So the part of this policy that controlled your decision was the requirement for CMO approval or the requirement that the surgery be determined medically necessary? I'm sorry, I think you're frozen. Can anybody hear the witness?

THE VIDEOGRAPHER: No, this is Neal, I don't hear him. You want to go off for a minute? It looks like they disconnected. We are going off the record at 1 p.m.

(Break was taken.)

THE VIDEOGRAPHER: We are back on the record at 1:03 p.m.

MR. CROSS: Can you read back the last question.

(Page 84, line 25 and page 85, lines 1-3 were read back.)

A That's what -- that's what I've been saying all along, it has to be medical necessity, and, in cosmetic situations, there has to be an CMO approval.

BY MR. CROSS:

Q So is it the requirement that there is a CMO approval, that controlled your decision, or is it the requirement that the surgery be medically necessary that controlled your decision?

MR. SCARBER: I'm just going to place

an objection to asked and answered. He indicated that -- asked and answered.
BY MR. CROSS:
Q Go ahead.
A I already said that it takes both.
Q It takes -- both of them controlled the decision; is that your answer?
THE COURT REPORTER: Can you repeat your question.
BY MR. CROSS:
Q Both of them controlled the decision; is that your answer?
A Yes.
Q Okay. So if it were not for the requirement for CMO approval, would you have approved the surgical consult for Mr. Jackson?
A No, it did not meet IQ and it is not medically necessary.
Q If this policy didn't exist, would you have approved the surgical consult for Mr. Jackson?
A No.
MR. SCARBER: I'm just going to place an objection. The policy does exist, and they're under obligation to follow the policies.

BY MR. CROSS:
Q Can I have your answer, sir?
A I believe you want to know if the policy did not exist would I have done it, correct?
Q Yes.
A No, the policy does exist.
Q That doesn't answer the question, sir. I'm asking you would you have done it if the policy did not exist?
A And I did answer that when I said there's no medical necessity and it doesn't meet IQ requirements.
THE COURT REPORTER: "And it doesn't meet" --
THE WITNESS: I'm sorry, InterQual, I-n-t-e-r-Q-u-a-l.
BY MR. CROSS:
Q So there was an InterQual review done for that request?
A Yeah, you want to see it?
Q I would love to.
A Right there. It says --
Q Hold on.
A -- "Criteria met: No."
Q Is this the form that you just showed me on the camera? I couldn't really see it.

A Yes.
Q Okay.
A Down at the bottom, right now, it says, "Criteria met: No."
Q And it says, "Criteria source: MNR, InterQual, Other"?
A It's InterQual.
Q So there's nothing next to "InterQual"; the "Criteria met" is "No."
A It is InterQual, that's all we use.
Q That's all you use. All right. Do you know if Corizon tracks any utilization management data for the Michigan contract?
A Do I know? I don't know.
Q You don't know whether they do or not.
MR. SCARBER: Just going to place an objection, asked and answered. He just answered the question.
A And I don't know what they track.
BY MR. CROSS:
Q I'm asking you do they track anything, in terms of utilization management --
MR. SCARBER: Object to form of the question. Same objection. Hey, Ian, ask the question again. It got broken up a little bit while

I was making my objection. Go ahead, I'm sorry.
BY MR. CROSS:
Q Does Corizon track any utilization management data at all for the Michigan contract?
A What do you mean by "utilization management data at all"? What is your definition? So I know what to answer you.
Q Well, I don't know specifically what they track, sir, and I'm trying to find out.
A You do know that they track percent ATPs.
Q Okay. What else do they track?
A I don't know.
Q The only thing you know about is percent ATPs.
A You showed it to me.
Q You don't know about anything else that they track?
A No, I do not. I am not --
MR. SCARBER: Enough; asked and answered three times, going on the fourth.
THE WITNESS: I know. Right. Okay. Thank you.
BY MR. CROSS:
Q Okay. These InterQual reviews --
THE COURT REPORTER: Excuse me?
BY MR. CROSS:
Q You've never seen the actual InterQual review

itself, you just get a "yes" or "no" checked by somebody; is that correct?
A Yes.
Q And the person who sends those "yes" or "no" checks is Lori Minor or is it ever someone else?
A Lori Minor.
Q Lori Minor, okay. Where are those InterQual reviews maintained?
A I don't know offhand.
Q You don't know.
MR. CROSS: All right, I don't think I have further questions.
MR. WILLIS: I have no questions.
THE VIDEOGRAPHER: Mr. Scarber, do you have any questions or --
MR. SCARBER: Yeah, I'm sorry.
THE VIDEOGRAPHER: I'm just making sure.
MR. SCARBER: Can you hear me okay if I'm not shown on the camera?
THE VIDEOGRAPHER: Yes, I hear you fine.
EXAMINATION
BY MR. SCARBER:
Q Dr. Papendick, Mr. Cross was just asking you some

questions about the MDOC policy and the policies that you said control this particular situation with Mr. Jackson.
Did you refer Mr. Cross to MDOC Policy 03.04.100, section about corrective and reconstructive surgery services --
A Yes.
Q AA, BB?
A Yes.
Q And those were the policies that you were following when you were determining whether or not Mr. Jackson would be -- whether there was medical necessity for Mr. Jackson with respect to his colostomy reversal request?
A Correct.
Q Do you write this particular policy?
A No.
Q Are you the final decision-maker as to whether or not Mr. Jackson would have received a colostomy reversal while he was in the Michigan Department of Corrections? Let me rephrase my question, strike it.
Are you the final decision-maker as to whether or not Mr. Jackson would have received a colostomy reversal surgery while he was in the

Michigan Department of Corrections?
A No.
Q Based upon your testimony, Dr. Papendick, are you really only the maybe first or second step in that process?
A Yes.
Q Did you specifically deny Mr. Jackson's request for a colostomy reversal?
A No.
Q Was the request denied based upon the Michigan Department of Corrections policy directive that we just discussed?
A Yes.
Q As far as you can recall, Dr. Papendick, after you made an initial review of this case regarding medical necessity, was there any appeal or response back to you, that you're aware of, requesting another review of Mr. Jackson's request for a colostomy reversal?
A No.
Q How does that process usually work? If an inmate requests a particular procedure, and, in this case, a colostomy reversal, and no medical necessity was determined, if an inmate wanted to continue to pursue this, at least through Corizon, as it

pertains to you, what would happen at that point?
A The provider who put in the initial request would do one of two things to an ATP: He would either accept it or he can appeal it to his RMD, regional medical director. The regional medical director then looks at the case and decides whether they agree with the ATP or want to overturn it. If they agree with the ATP, the provider can take it to the state medical director for Corizon and continue the appeal. We then meet on Monday, Wednesday and Thursday evenings and make decisions about that specific case. If -- and that's considered the state medical director's decision. If the state medical director ATPs, and the provider still wants to appeal, he can appeal to the Michigan Department of Corrections, who, ultimately, the appeal would then be to the CMO for Michigan Department of Corrections.
Q So if I understand your testimony just now, there are several steps that an inmate may pursue regarding a request for a colostomy reversal that go beyond and above you.
A Correct.
MR. CROSS: Objection; misstates testimony.
THE WITNESS: What did he say?

What'd she say?
MR. SCARBER: That's okay.
BY MR. SCARBER:
Q Have you been provided with any information, that you're aware of, where additional steps, in terms of an appeal to the Corizon process, took place beyond what the inmates -- what the inmate originally sought in his 407 request back in 2018?
A No.
Q There's an allegation from the plaintiff that says that Dr. Papendick is an official with final decision-making authority with respect to whether 407 requests from an on-site MP are approved or ATP. Is that a false statement?
A That's a false statement. I am not the final decision-maker.
Q In this particular case, Dr. Papendick, the plaintiff has supplied documents and represented that he filed an appeal with the MDOC in this particular case. What I want to show you now is what we have -- what I'll identify is ECF No. 12-9, page ID 268, it's entitled Step II Grievance Appeal Response, and this was submitted with the plaintiff's complaint.
Can you just take a look at that for

a second. While you're reading that, I'll make a statement for the record. It's going to be difficult for me to do screen sharing on my end, just 'cause I'm right here with the witness and trying to face him and the computer and all that stuff. So, I'll reference, to the best of my ability, any pages in the record that I'm going to refer to.
A Go ahead, I've probably read enough to tell you what you need.
Q So, based upon this grievance appeal response, would it be accurate to say that it was the MDOC who denied Mr. Jackson's colostomy reversal?
A Actually, it is. The grievance process is an MDOC process that's equivalent to the Corizon appeals process. So, if there had been a reason to overturn the reason for -- or the fact that there was no medical necessity, it could have been done here and it would have gone to the CMO, and the CMO could have then changed it. But they're in agreement with the Corizon system, as far as the need for that surgery or consult for surgery.
Q Does this particular document that we just read, Step II Grievance Appeal Response, does it indicate, down in the conclusion, that the Policy Directive

03.04.100 Health Service is a basis for the conclusion of denying this request?
A That would be correct.
Q Can you read the "Grievance Denied" section down at the bottom of this particular page where it references Mr. -- starting with "Mr. Jackson."
A Yeah.
Q And you can stop after that, the cap letters right there, can you read that for the record.
A Yes. "Mr. Jackson, per documentation, you are doing fine with current condition. The reversal is a major surgery with potential complications up to death and the Department will not okay a dangerous, unnecessary elective procedure. A reversal for a functioning" -- excuse me, "a functional colostomy is considered nonessential. Policy is no reversals unless there is medical reason."
Q And this particular denial here, the basis for this denial, again, is coming from the MDOC; is that correct?
A That's correct, I have nothing to do with the grievance process.
Q There's a Step III part to this particular document. Can you just take a look at that for a second and then I'll ask you some questions.

MR. SCARBER: Now, counsel, I'm referring to the Step III part at page ID 269.
BY MR. SCARBER:
Q Just take a look at that and I'll ask you some questions.
A Okay.
Q Does this particular grievance response, is this prepared by Corizon?
A No.
Q Is this something from the MDOC?
A It's from the MDOC; it says, "Response of the Bureau of Health Care Services," which is over the Michigan Department of Corrections.
Q Okay. And does this particular grievance say anything about what a disagreement with a plan of care is?
A It says, "Disagreement with plan of care does not support a denial of care or inadequate medical treatment."
Q Does this particular grievance response by the MDOC indicate anything about what will happen -- what the result is of this particular Step III process of the grievance response?
A "Grievant appeal denied."
Q And, again, is this document something from the

MDOC?
A Correct.
Q And, in fact, is it true that the two documents that I just read to you, the Step II process, grievance appeal response, as well as the Step III grievance response, both come well after anything you would have reviewed back in -- or done with respect to the request back in April of 2017?
A Correct.
Q In fact, is the date of the Step II grievance appeal response --
A June 8th of 2017.
Q And how about the date of the Step III grievance response denying his appeal?
A It was signed 10-13 of 2017, the manager. . .
Q There's two dates on here. Would it be fair to say, though, that this response is done in late October of 2017?
A Correct, it was finished then.
Q And as far as you're aware, were any other appeals made to you with respect to this process?
A None.
Q Any other appeals made to Corizon with respect to this process?
A Not that I could find.

Q I want you to take a look at what I'm going to identify as ECF No. 12-7, page ID 261. This is a letter of the Office of Legislative Corrections Ombudsman. And can you read this sentence that I have highlighted here in the first paragraph -- or the second paragraph of page one of this letter.
A "Corrective and reconstructive surgery shall be authorized for a prisoner only if determined medically necessary and only if approved by the CMO."
Q And does this letter indicate that it's referencing Policy Directive 03.04.100?
A Yes, sir.
Q Sections "AA" and "BB"?
A Yes, sir.
Q And you indicated that, based upon your understanding, Mr. Jackson's colostomy reversal procedure would be considered reconstructive surgery under those categories?
A That's correct.
Q When determining whether or not there's medical necessity, you indicated something about considering the risks of a particular procedure versus the benefits?
A Correct.

Q Explain that again; what were you discussing about that.
A If the risk is higher than the benefit, then it's not worth doing the procedure. If the benefit is higher than the risk, then it's worth doing the procedure.
Q Are some of the risks -- well, let me ask you this: What are some of the risks associated with doing a colostomy reversal?
A Death. Death, three percent.
THE COURT REPORTER: What was the percentage?
A Three. And you might find a provider who's a little less, but, in general, it's three percent.
Q Plaintiff's counsel, Mr. Cross, asked you some questions about were you aware that Mr. Jackson had the colostomy reversal after, at some point -- at some point in time after he was released from the MDOC.
A Correct.
Q And can you take a look at this document here, which we're going to -- which I'll identify here as the operative report of June 19th of 2019. It is from the DMC records, page 574 through 579. Just take a look at the front and back of pages 574 and 575 for

me, please.
A Okay.
Q In the "Indications for Procedure" section on page 575 of this document, does it indicate here anything about whether or not Mr. Jackson now has any issues?
A No, he actually says he now has no issues.
Q At the bottom of this particular paragraph in the "Indications for Procedure," the first paragraph, does doctor -- does the surgeon who performs the reversal talk about the potential risks of this particular procedure?
A Yes, he says, "All risks and benefits of the procedure, including but not listed to the risk to heart attack, stroke, death, infection, the potential need for a reoperation, the potential for a leak and potential for damage to surrounding structures, including the ureter, general urinary system," and the patient signed the consent.
Q Now, let me ask you about those particular risks. Are those some of the risks that you have to consider when you're trying to follow the MDOC's policy regarding determining medical necessity and whether -- and in the manner in which you're considering your evaluation of an ATP?
MR. CROSS: Objection.

A Yes. Interestingly, that is the list of the damage or the danger that we give the patient normally. So, a good share of them will refuse to have those kind of surgeries because of the risk and the benefit ratio, and, in this case, it's not small.

BY MR. SCARBER:

Q We took the deposition of Mr. Jackson's original surgeon who performed the colostomy reversal, Dr. Kansakar, and she indicated that, irrespective of a person's age or comorbidities, that these are still risks that can occur.

A That's correct.

Q You would agree with that?

A Absolutely.

Q Doctor, we've had an opportunity for you to look at the grievance response from the MDOC, and did you see the references in this particular grievance where it referenced that there were no urgent medical issues reported from the surgeon's office and the colostomy is functional? Do you see that reference?

A Yes.

Q There's a note in the MDOC records, page 72, that I will read, or at least show you. Can you take a look at this particular note here.

A Okay.

Q Does this particular note indicate that --

A It indicates that there's no urgent medical issues reported from the surgeon's office and the colostomy is functional.

Q Would that be an indication to you that would support your determination that there was no medical necessity for Mr. Jackson's colostomy reversal at the time that you were presented with that request?

A Yes.

Q Doctor, I want you to now take a look at MDOC records, the records are pages 62 through 65, and these records are from April the 7th of 2017. Can you just take a look at the record and then I'll ask you a question or two. Just look at it so we can get some kind of understanding or context.

Does this record indicate to you that Mr. Jackson's colostomy is functioning appropriately?

A Yeah, "Stoma is pink and" -- "deep pink and functioning with soft light brown stool and no evidence of blood or blood in the stool. Continues to verbalize that ostomy has to be temporary and reversed. No medical necessity per outside documentation from" -- "or from conversation with surgeon's office, Dr. Kansakar, who was the first physician who did the colostomy."

Q Based upon that particular record, would that record support the decision that you came to that there was no medical necessity at the time that you reviewed Mr. Jackson's case, at least back in April of 2017?

A Yes.

Q And just so we're clear, the only involvement that you had in this particular incident would have been in April of 2017, correct?

A Correct.

Q Mr. Cross, plaintiff's counsel, asked you some questions about whether you were critical of other doctors and what your opinions were of what other doctors did. I want you to assume that plaintiff's surgeon, Dr. Kansakar, has testified in this particular case that the determination of various medical procedures, including whether to do a colostomy reversal, when to do a colostomy reversal, how to do it, the timing of when to do it, is something that is up to the medical judgment of different providers in determining what the plan of treatment should be for a particular patient. Would you agree with that?

A Yes.

Q So when you were asked about what another doctor did, do you focus more on the information that you have in front of you at the time to help you make a determination about medical necessity or do you focus on what another doctor does three or two-and-a-half years later?

A I only have data for what we're doing at the time, so I can only use data for what's going on at the time to make my decision.

Q And you allow yourself to use your medical judgment and allow other doctors to use their medical judgment.

A Correct.

Q And there was a particular portion that we read in the Step III grievance response that specifically talked about medical opinions; do you recall that?

A Not offhand.

Q Give me one second. And the response indicated something like 'a difference of medical opinion is not a denial of care.'

A Correct.

Q You would agree with that.

A Yes.

Q Based upon all of the information that we have discussed just now that you have reviewed concerning

your involvement in this particular matter, do you believe that your recommendation at the time of April 19th of 2017 was the appropriate recommendation at that time?

A Without question.

MR. SCARBER: I don't anything further for the witness at this time.

MR. CROSS: I have some, few more follow-up questions.

EXAMINATION

BY MR. CROSS:

Q You were just asked by your attorney, Dr. Papendick, about a variety of sections from Mr. Jackson's medical records. Did you review those medical records at the time you made the decision to issue an ATP in April of 2017?

THE WITNESS: I didn't hear what he said.

BY MR. CROSS:

Q I'm sorry.

MR. SCARBER: He didn't hear you, but I heard you, and so what I'm going to at least do is object to foundation of the question just because some of the reference I referenced hadn't even occurred yet.

MR. CROSS: Okay.

MR. SCARBER: Yeah.

BY MR. CROSS:

Q So, Dr. Papendick, your attorney just asked you a series of questions about Mr. Jackson's medical records. Did you review those medical records at the time you issued the ATP in April of 2017 or any of them?

A I usually do look at the medical records, unless everything I need is in the 407.

Q Okay. Was everything you needed in the 407?

A I cannot tell you that, that was a few years ago.

Q Let's look at the 407, then. Can you see it?

A Yeah, I have it here in front of me also.

Q Was everything you needed in that 407?

A As far as can I see, yes.

Q So would it be fair to say that you did not review other medical records outside of the 407?

A That is not a fair question.

Q Can you answer it?

A I don't know. I already told you that answer.

Q So you don't remember if you reviewed any records or not.

A Correct. And would it be your custom, habit or practice to review records outside the 407 if the 407 contains all the information that you need to make a determination?

MR. SCARBER: I'm just going to place an objection to asked and answered. He's already kind of explained his position on that. But go ahead.

A I already said it depends on what is there. And he didn't meet InterQual. I may have. That's all I'm going to say.

BY MR. CROSS:

Q Okay. Your attorney asked you some questions about age or comorbidities and whether risks exist, regardless of age and comorbidities, in a surgical procedure, such as a colostomy take-down.

A Was there a question there?

Q Yes --

MR. SCARBER: He's laying his foundation.

THE WITNESS: Oh, okay.

BY MR. CROSS:

Q -- I'm just explaining what part of the record we're going to. Do the age or comorbidities of the patient generally affect the level of risk involved with a surgical procedure?

A It depends on the comorbidity in the -- and the medical condition. I mean, I can't make a generalized statement.

Q Okay. Well, is it possible for certain comorbidities to increase the risk involved in a surgical procedure?

MR. SCARBER: Just going to place an objection to the term "possible." I suppose anything is possible.

A Are you asking me about this patient's comorbidities?

BY MR. CROSS:

Q I'm asking you in general.

MR. SCARBER: Object to relevancy. If you can answer his question, answer the question. I'm still going to make my objection, asked and answered.

A It can't be -- you can't make a statement, you just can't make a flat-out statement like that. Depends on what is happening. It's just not necessarily true.

BY MR. CROSS:

Q Okay. So, for example, I believe you testified that the risk of death with a colostomy reversal procedure is three percent.

A Anesthesia, three percent, flat-out.

Q Any procedure using general anesthesia has a three percent chance of death.
A Correct.
Q Okay. Does that chance of death change ever based on the age or the comorbidities?
A No.
Q No.
A Not necessarily. And I've answered that before.
Q So every patient has a three percent chance of death.
A Yes. If you go in -- nevermind.
Q Go ahead --
A Yes, every patient, three percent chance of death.
Q There are no patients for which the risk is higher?
A Might be higher, but everybody has three percent.
Q I understand the average is three percent, but I'm asking --
A No, no, everybody has a three percent chance risk. Anything else adds onto it.
Q Okay.
A So do you want to be one of three out of hundred who dies because they went under anesthesia? Is that what you want? I mean, is that what I got to do to prove it to you?
Q I'm asking the questions, sir.

A Yeah, I know.
Q So you're saying that the baseline is three percent and it can go up with age or comorbidities; is that your testimony? Certain things could increase the risk, but the risk can never be lower than three percent.
A My testimony is you have three percent risk for going under anesthesia, that's my testimony.
Q For everyone, and it is not --
A Every age, everyone.
MR. SCARBER: I'm going to place an objection again, asked and answered.
BY MR. CROSS:
Q We talked a bit about the appeals process for Corizon.
A Okay.
Q Can a prisoner initiate an appeal of an ATP?
A It's an MDOC --
Q Through the Corizon process -- I'm not done with my process, sir -- through the Corizon appeals process can a prisoner initiate an appeal?
A I have the same response: Through a grievance with the MDOC or having his provider put in a grievance -- or an appeal to the Corizon process.
Q All right. Do you know the percentage of your ATPs that are appealed through the Corizon appeals process?
A I could speculate, but no.
Q Can you give me an estimate? Is it one percent? Is it 50 percent?
MR. SCARBER: Just going to place an objection; calls for speculation.
A No, I already said that.
BY MR. CROSS:
Q I understand. So you don't know if it's 99 percent? Is it 99 percent?
A No, I do not know how many get appealed. I don't even know that they've been appealed.
Q I see.
A I get no notification.
Q I believe you testified previously that you have approved colostomy reversal surgeries for prisoners.
A Okay.
Q What happened after you approved it?
A It got repaired.
Q Okay. So, if you had approved Mr. Jackson's request, he would have received the surgery or at least the consultation?
A Yes.
Q Okay. Is there a difference between medically indicated and medically necessary care?

A I guess you could say so.
Q What is that difference?
A One is medically necessary and the other one is approvable.
Q Is what?
A Approvable.
Q Approvable. So there are some things that are approvable that are not medically necessary?
A It depends on the insurance company and what kind of approvals they have.
MR. SCARBER: I'm going to place an objection to relevance, unless you're talking about specific MDOC policy and what's going on with the inmates at the Michigan Department of Corrections.
BY MR. CROSS:
Q Who is Kalen -- well, you know what, that's outside the scope.
MR. CROSS: I don't think I have further questions. Thank you for your time, Dr. Papendick.
THE WITNESS: Thank you.
MR. SCARBER: Ken?
MR. WILLIS: I don't have any questions.

EXAMINATION

BY MR. SCARBER:

Q Doctor, just one last question for me. Mr. Cross asked you a question about what would happen if you had found, based upon your review with the information you had, about something being medically necessary in terms of a colostomy reversal.

A Right.

Q Does that process still have to go through, even after you say it's medically necessary, does it still have to go through the -- be consistent with the MDOC policy that we discussed?

A Well, I really believe that this would be evaluated by the State of Michigan -- or, no, the state medical director for Corizon before it went to surgery because of that statement. Yes, it's going to have to be reviewed by the medical director for the Michigan Department of Corrections.

Q So irrespective of whatever you would do with respect to your evaluation, it still has to go through the process of getting some kind of final approval from the other bodies or process that we talked about that involved the MDOC's policy.

A Correct, it's still going to have to go back to the medical CMO.

MR. SCARBER: Okay. I have nothing further. Thank you.

MR. CROSS: All right. I don't have any recross.

THE VIDEOGRAPHER: Okay. That's concludes today's testimony. We are off the record at 1:54 p.m.

(The virtual, videotaped deposition concluded at 1:54 p.m.)

CERTIFICATE OF NOTARY

STATE OF MICHIGAN)
) SS
COUNTY OF LIVINGSTON)

I, Carol Marie Hicks, Certified Shorthand Reporter, a Notary Public in and for the above county and state, do hereby certify that the above deposition was taken before me at the time and place hereinbefore set forth; that the witness was by me first duly sworn to testify to the truth, and nothing but the truth, that the foregoing questions and answers made by the witness were duly recorded by me stenographically and reduced to computer transcription; that this is a true, full and correct transcript of my stenographic notes so taken; and that I am not related to, nor of counsel to either party nor interested in the event of this cause.

Carol Marie Hicks
CSR 3345 Notary Public,
Livingston County, Michigan

My Commission expires: September 4, 2021

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